PEDIATRIC

BASIC LIFE SUPPORT GUIDELINE

PEDIATRIC ASSESSMENT

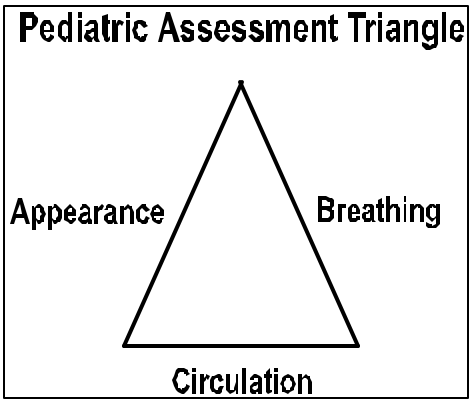
INDICATIONS:
Care of the pediatric patient always begins with assessment. This is the most important and often the most challenging step. In the prehospital setting there are 2 key issues:

1. What vital physiologic functions are effected?
2. How severe is the physiologic abnormality: stable, unstable, or critical?

1. Scene size up:
   - Identify possible hazards
   - Assure safety of responder and patient
   - Observe for mechanism of injury/illness
   - Note anything suspicious
   - Medications, chemicals, other ill persons
   - Assess any discrepancies between history and presentation
   - Use Body Substance Isolation precautions
   - Determine number of patients

2. Form an initial impression:

Start out a little distance away from the patient and take a minute or so to form a first impression of the child's condition



- **Appearance** refers to the child's mental status, muscle tone, and body position.
  - Normal muscle tone, and body position for age = nonurgent; continue with assessment
  - Anything else (floppy, stiff, unable to sit) =urgent, begin immediate interventions as needed.
- **Breathing** includes the presence or absence of visible movement at the chest or abdomen and signs of breathing effort:
  - Visible movement of chest or abdomen without obvious sounds or effort = nonurgent; continue with assessment.
  - No visible movement or obvious struggle to breathe = urgent; begin immediate airway and breathing interventions as needed.
- **Circulation** refers to the child's skin color.
  - Pink skin color = nonurgent; continue with assessment
  - Pale, bluish, or mottled color = urgent; begin immediate interventions as needed.
    - Infants may have bluish color to hands, feet, and around lips as a normal finding. Blueness to the inside of the mouth and tongue is always abnormal.

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3. Perform an Initial Assessment
   - Smile
   - Speak slowly and in a quiet even tone
   - Approach the child at their level
   - Keep small children with their caregiver
   - Make as many observations as possible before touching the patient
   - Adolescents may require interviewing without caregiver present to obtain accurate information about medical history, but always have 2 personnel present

4. Special considerations when performing a **Trauma Assessment:**
   - **A. Airway –** open with jaw thrust to maintain neutral neck position, have suction ready
   - **B. Breathing –** give 100% O2
   - **C. C – Spine –** consider mechanism of injury, evidence of injury involving head or spine, or complaints of weakness, numbness, spinal pain
   - **D. Circulation –** bleeding control, shock position if no head injury, splint fractures if patient is stable, MAST trousers are not indicated for hypotension, use to splint unstable pelvic fractures
   - **E. Disability (AVPU) –** assure maintenance of adequate ventilation
   - **F. Expose* and examine -** examine the back while immobilizing, keep child warm

**Note: Children lose body heat quickly, so it is important to remove coverings only as needed to perform assessments and interventions, Keep exposed areas covered and ensure the child stays warm. For patients older than about eighteen months who appear generally alert, clothing removal should be done in a manner that respects their modesty.*

Age	*HR+*		*BP~*	*RR*
	Low	High		
Infant (birth–1 year)	**100**	**160**	**greater than 65***	30–60
Toddler (1–3 years)	**90**	**150**	**greater than 85***	24–40
Preschooler (3–6 years)	**80**	**140**	**greater than 90**	22–34
School-age (6–12 years)	**70**	**120**	**greater than 95**	18–30
Adolescent (12–18 years)	60	100	greater than 100	12–16

+Note: Pulse rates for a child who is sleeping may be 10 percent lower than the low rate listed.
~ Note: BP is based on 80+2xage to maximize sensitivity in detecting unstable patients.
**Note: In infants and children aged three years or younger, the presence of a strong brachial or femoral pulse should be substituted for a blood pressure reading.*

Indicators of hypoperfusion in children:	
▪ Respiratory difficulty ▪ Cyanosis despite O2 administration ▪ Truncal cyanosis and coolness	▪ Hypotension ▪ No palpable blood pressure ▪ Weak, thready, absent pulses ▪ Decreasing consciousness

5. Detailed assessment according to severity of physiologic abnormality.

- **Stable or no abnormality:**
  - Detailed physical exam
  - Focused history (SAMPLE)
    - Signs/symptoms
    - Allergies
    - Medications
    - Past pertinent medical history
    - Last oral intake
    - Events leading to call
  - Transport and treatment according to appropriate guidelines and protocols
  - Reassess every 15 minutes
- **Unstable:**
  - Abbreviated history while preparing child for transport:
    - Events leading to call
    - Past medical history
    - Medications and allergies if time allows
  - Immediate transport and treatment according to appropriate guidelines and protocols
  - Reassess every 5 minutes